		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025346

Facility Name: Little Sisters of the Poor

Address: 2325 N. Lakewood (Number) Chicago (City) 60614 (Zip Code)

County: Cook

Telephone Number: (773) 935-9600 **Fax #** (773) 935-9614

IDPA ID Number: 36-2482272 / 001

Date of Initial License for Current Owners: 05/01/80

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mother Patricia Gertrude Friel **Telephone Number:** (773) 935-9600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mother Patricia Gertrude Friel

(Title) President

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Elizabeth Vaccariello, Vice President

(Firm Name & Address) Varey & Vaccariello CPAs PC, 617 E Golf Road, Suite 107, Arlington Heights, IL 60005

(Telephone) (847) 228-6977 Fax # (847) 228-0317

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 01/11/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	28	Skilled (SNF)	26	9,510	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	53	19,495	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	79	29,005	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	18,992	2,835		21,827	10
11	ICF/DD					11
12	SC		1,721		1,721	12
13	DD 16 OR LESS					13
14	TOTALS	18,992	4,556		23,548	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.19%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 05/01/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/1980 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	343,441	20,442	91,349	455,232		455,232		455,232			1
2	Food Purchase		176,920		176,920		176,920	(83,328)	93,592			2
3	Housekeeping	242,235	27,780		270,015		270,015		270,015			3
4	Laundry	74,904	10,389	27,523	112,816		112,816	(3,984)	108,832			4
5	Heat and Other Utilities			317,679	317,679		317,679	(107,645)	210,034			5
6	Maintenance	195,242	71,588	228,200	495,030		495,030	(66,789)	428,241			6
7	Other (specify):*			86,148	86,148		86,148		86,148			7
8	**TOTAL General Services**	855,822	307,119	750,899	1,913,840		1,913,840	(261,746)	1,652,094			8
	B. Health Care and Programs											
9	Medical Director			500	500		500		500			9
10	Nursing and Medical Records	1,067,045	25,279	128,494	1,220,818		1,220,818		1,220,818			10
10a	Therapy	57,012	20	269	57,301		57,301		57,301			10a
11	Activities	70,684	20,042	55,488	146,214		146,214		146,214			11
12	Social Services	39,410			39,410		39,410		39,410			12
13	Nurse Aide Training											13
14	Program Transportation			3,622	3,622		3,622		3,622			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,234,151	45,341	188,373	1,467,865		1,467,865		1,467,865			16
	C. General Administration											
17	Administrative			12,000	12,000		12,000		12,000			17
18	Directors Fees											18
19	Professional Services			51,793	51,793		51,793	(3,370)	48,423			19
20	Dues, Fees, Subscriptions & Promotions			45,098	45,098		45,098	(28,823)	16,275			20
21	Clerical & General Office Expenses	193,470	13,859	131,368	338,697		338,697	(17,176)	321,521			21
22	Employee Benefits & Payroll Taxes			476,241	476,241		476,241		476,241			22
23	Inservice Training & Education			2,798	2,798		2,798		2,798			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			10,867	10,867		10,867		10,867			25
26	Insurance-Prop.Liab.Malpractice			29,505	29,505		29,505	(3,797)	25,708			26
27	Other (specify):* Bad Debts			19,092	19,092		19,092	(19,092)				27
28	**TOTAL General Administration**	193,470	13,859	778,762	986,091		986,091	(72,258)	913,833			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,283,443	366,319	1,718,034	4,367,796		4,367,796	(334,004)	4,033,792			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Little Sisters of the Poor #0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			506,836	506,836		506,836	(36,512)	470,324			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			117,699	117,699		117,699	(117,699)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			624,535	624,535		624,535	(154,211)	470,324			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,836		3,836		3,836		3,836			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,508	43,508		43,508		43,508			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		3,836	43,508	47,344		47,344		47,344			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,283,443	370,155	2,386,077	5,039,675		5,039,675	(488,215)	4,551,460			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(83,328)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,843)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,984)	4		8
9	Non-Straightline Depreciation	(36,512)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(17,176)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(117,699)	32		14
15	Non-Care Related Owner's Transactions	(104,802)	5		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(12,637)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(3,797)	26		21
22	Special Legal Fees & Legal Retainers	(3,370)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,092)	27		24
25	Fund Raising, Advertising and Promotional	(28,823)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(54,152)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (488,215)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (488,215)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Little Sisters of the Poor

ID# 0025346

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Line 15 - Non-Care Related Owner's Transactions	$ (54,152)	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(54,152)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(83,328)	0	0	0	0	0	0	0	0	0	0	(83,328)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(3,984)	0	0	0	0	0	0	0	0	0	0	(3,984)	4
5	Heat and Other Utilities	(107,645)	0	0	0	0	0	0	0	0	0	0	(107,645)	5
6	Maintenance	(66,789)	0	0	0	0	0	0	0	0	0	0	(66,789)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(261,746)	0	0	0	0	0	0	0	0	0	0	(261,746)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,370)	0	0	0	0	0	0	0	0	0	0	(3,370)	19
20	Fees, Subscriptions & Promotions	(28,823)	0	0	0	0	0	0	0	0	0	0	(28,823)	20
21	Clerical & General Office Expenses	(17,176)	0	0	0	0	0	0	0	0	0	0	(17,176)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(3,797)	0	0	0	0	0	0	0	0	0	0	(3,797)	26
27	Other (specify):*	(19,092)	0	0	0	0	0	0	0	0	0	0	(19,092)	27
28	**TOTAL General Administration**	(72,258)	0	0	0	0	0	0	0	0	0	0	(72,258)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(334,004)	0	0	0	0	0	0	0	0	0	0	(334,004)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Little Sisters of the Poor # 0025346 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(36,512)	0	0	0	0	0	0	0	0	0	0	(36,512)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(117,699)	0	0	0	0	0	0	0	0	0	0	(117,699)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(154,211)	0	0	0	0	0	0	0	0	0	0	(154,211)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(488,215)	0	0	0	0	0	0	0	0	0	0	(488,215)	45

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Little Sisters of the Poor - Chicago		
				Province, Inc.	Palatine, IL	Religious Order
				LSP - St. Joseph's Home for the		
				Elderly	Palatine, IL	Nursing Home

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ -0-			$ -0-	$ * -0-	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Little Sisters of the Poor											10
11	- Chicago Province, Inc.	X		Obtain Funds to Advance to	NONE	09/29/99	2,000,000		09/29/04	0.0300	117,699	11
12				LSP Northside, Inc. to								12
13				Replace HUD Mortgage								13
14	TOTAL Non-Facility Related						$ 2,000,000	$			$ 117,699	14
15	TOTALS (line 9+line14)						$ 2,000,000	$			$ 117,699	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	-0-	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	-0-	2
3. Under or (over) accrual (line 2 minus line 1).	$	-0-	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	-0-	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	-0-	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	-0-	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	-0-	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	-0-	8
	1997	-0-	9
	1998	-0-	10
	1999	-0-	11
	2000	-0-	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Little Sisters of the Poor COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0025346

CONTACT PERSON REGARDING THIS REPORT Mother Patricia Gertrude Friel

TELEPHONE (773) 935-9600 FAX #: (773) 935-9614

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 117,137 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

LSP - Jugan Terrace Apartments - Housing Unit for the Elderly
At the beginning of the year this was a separate entity. During 2001, the corporation was megered into Little Sisters of the Poor of Chicago, Inc. St. Mary's Home. So it is NOT a separate entity. The APT Facility is NOT run as a business, but is a part of the mission of the Little Sisters of the Poor - taking care of the elderly poor. Expenses for the apartments are NOT included in this cost report.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Existing Structure	195,291	1979	$ 558,496	1
2					2
3	TOTALS	195,291		$ 558,496	3

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	79		1980	1980	$ 7,986,351	$ 229,150	40	$ 199,659	$ (29,491)	$ 4,318,270	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fencing & Electric Gates, Parking Misc Electric & Landscaping			1981	274,725	7,883	40	6,868	(1,015)	140,901	9
10	Sliding Gates, Misc Electric & Decorating			1982	9,877	283	40	247	(36)	4,817	10
11	Building Renovation			1983	10,031	288	40	251	(37)	4,655	11
12	Land Improvement - Landscaping			1983	3,265	187	20	163	(24)	3,018	12
13	Construction of Beauty Shop			1984	27,853	799	40	696	(103)	12,191	13
14	Kitchen Tile, Lighting, Ice Cream Parlor, Reception Area, Closets			1985	41,873	1,201	40	1,047	(154)	17,285	14
15	Land Improvement - Covered Walkway, Concrete Patios			1985	72,492	4,160	20	3,625	(535)	59,842	15
16	Land Improvement - Parking Lot Lights, Park Area			1986	12,805	735	20	640	(95)	9,928	16
17	New Garage			1986	40,590	1,165	40	1,015	(150)	15,768	17
18	Chapel Renovation			1988	66,715	1,914	40	1,668	(246)	22,525	18
19	Electric Work for New Garage			1989	7,615	219	40	191	(28)	2,387	19
20	Garage Completion, Repiping Storage Facility			1990	154,974	4,447	40	3,875	(572)	44,580	20
21	Land Improvement - Paving/Resurface Parking Lots			1990	27,860	1,599	20	1,393	(206)	16,028	21
22	Boiler Room Floor Drains			1991	6,413	184	40	160	(24)	1,680	22
23	Land Improvement - New Sidewalks			1996	3,050	175	20	152	(23)	836	23
24	Senior Center, Physical Therapy & Elevator Renovation			1997	332,952	9,553	40	8,324	(1,229)	37,458	24
25	Walkway Renovation			1997	222,446	6,383	40	5,561	(822)	25,025	25
26	Combining of Rooms and Room Conversions			1997	37,098	1,064	40	927	(137)	4,172	26
27	Senior Center and Physical Therapy			1998	7,258	208	40	182	(26)	637	27
28	Kitchen Renovation			1999	711,148	20,404	40	17,779	(2,625)	44,447	28
29	Window Replacements			1999	239,657	6,876	40	5,991	(885)	14,978	29
30	2nd Floor Room Renovations			1999	162,707	4,670	40	4,068	(602)	10,170	30
31	Land Improvement - Brick Paving of Second Courtyard			2000	16,555	950	20	828	(122)	1,242	31
32	Window Replacements			2000	271,260	7,783	40	6,781	(1,002)	10,171	32
33	Auditorium Roof			2000	50,927	1,461	40	1,272	(189)	1,908	33
34	Two New Electric Front Doors			2001	2,645	38	40	33	(5)	33	34
35	Land Improvement - Concrete Walk and Base			2001	2,527	73	20	63	(10)	63	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capital Building Repair - Per P/A Desk Audit	1985	$ 41,413	$	40	$ 1,035	$ 1,035	$ 17,605	37
38	Capital Building Repair - Per P/A Desk Audit	1986	42,062		20	2,103	2,103	33,666	38
39	Capital Building Repair - Exterior Doors	1995	3,986		10	399	399	2,793	39
40	CBR - Window, Door Gate, Smoke Detect, Heat Pump	1997	40,893		5	8,179	8,179	36,805	40
41	CBR - Tuckpointing, Repair Work, Sewer & Doors	1998	131,347		20	6,567	6,567	22,985	41
42	Capital Building Repair - Tank Removal	1999	10,761		5	2,152	2,152	5,380	42
43	CBR - Electric Alt, Chiller and Fire System Repair	2000	17,825		5	3,565	3,565	5,347	43
44	CBR - Heat Pump, Door, Flooring, Drapes, Signs and Heater	2001	47,182		5	4,718	4,718	4,718	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,139,138	$ 313,852		$ 302,177	$ (11,675)	$ 4,954,314	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	95 Dodge Van	1994	$ 27,745	$	$	$	4	$ 27,745	76
77	Care Use	95 Jeep Eagle Sta Wagon	1995	9,354				4	9,354	77
78	Care Use	96 Chevy Bus	1996	45,374				4	45,374	78
79	Care Use	96 Buick 4dr	1996	11,784				4	11,784	79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,577,119	$ 182,565	$ 159,069	$ (23,496)	10 Years	$ 613,830	71
72	Current Year Purchases	31,235	1,792	1,561	(231)	10 Years	1,561	72
73	Fully Depreciated Assets	517,879				10 Years	517,879	73
74								74
75	TOTALS	$ 2,126,233	$ 184,357	$ 160,630	$ (23,727)		$ 1,133,270	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Use	97 Dodge Maxi Van	1997	$ 16,557	$ 2,375	$ 2,070	$ (305)	4	$ 16,557	76
77	Care Use	01 Ford Taurus	2001	16,957	2,433	2,120	(313)	4	2,120	77
78	Care Use	01 Ford F150 w/Pl & Spdr	2001	26,618	3,819	3,327	(492)	4	3,327	78
79										79
80	TOTALS			$ 154,389	$ 8,627	$ 7,517	$ (1,110)		$ 116,261	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,978,256	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 506,836	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 470,324	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (36,512)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,203,845	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Bldg - Convent Allocation Various	$ 1,595,813	$ 40,393	$ 740,469	86
87	Equip - Convent Allocation Various	314,067	23,727	167,394	87
88	Vehicles - Convent Allocation Var	22,805	1,110	17,173	88
89					89
90					90
91	TOTALS	$ 1,932,685	$ 65,230	$ 925,036	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	$ -0-	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

* ALL AIDES EMPLOYED HAVE PREVIOUSLY OBTAINED THE NECESSARY TRAINING

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	39-2	visits				3,836		3,836	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 3,836		$ 3,836	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 857,686	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	504,652		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	948,390		5
6	Prepaid Insurance	21,090		6
7	Other Prepaid Expenses	20,367		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Donations Receivable	186,211		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,538,396	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	641,000		13
14	Buildings, at Historical Cost	12,399,482		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,617,494		16
17	Accumulated Depreciation (book methods)	(6,999,582)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,658,394	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,196,790	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,161	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	101,710		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 131,871	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 131,871	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,064,919	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,196,790	$	48

*(See instructions.)

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,215,292	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,215,292	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(150,373)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (150,373)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,064,919	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,670,566	1
2	Discounts and Allowances for all Levels	(169,392)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,501,174	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	2,371,239	24
25	Interest and Other Investment Income***	(287)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,370,952	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Management Fees (Adjusted Out on Sch V)	17,176	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,176	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,889,302	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,913,840	31
32	Health Care	1,467,865	32
33	General Administration	986,091	33
	B. Capital Expense		
34	Ownership	624,535	34
	C. Ancillary Expense		
35	Special Cost Centers	3,836	35
36	Provider Participation Fee	43,508	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,039,675	40
41	**Income before Income Taxes (line 30 minus line 40)****	(150,373)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (150,373)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,165	1,348	$ 40,018	$ 29.69	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,894	14,623	339,184	23.20	3
4	Licensed Practical Nurses	5,164	5,789	119,826	20.70	4
5	Nurse Aides & Orderlies	42,338	49,209	547,646	11.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,434	4,418	57,012	12.90	8
9	Activity Director	1,919	2,008	28,646	14.27	9
10	Activity Assistants	3,546	3,932	42,038	10.69	10
11	Social Service Workers	1,495	1,690	39,410	23.32	11
12	Dietician					12
13	Food Service Supervisor	721	738	10,506	14.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,039	36,941	332,935	9.01	15
16	Dishwashers					16
17	Maintenance Workers	10,861	12,514	195,242	15.60	17
18	Housekeepers	22,206	25,313	242,235	9.57	18
19	Laundry	7,343	8,363	74,904	8.96	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,279	14,242	193,470	13.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,597	1,796	20,371	11.34	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	162,001	182,924	$ 2,283,443 *	$ 12.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	147	$ 5,143	1-3	35
36	Medical Director	10	500	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	93	2,789	10-3	39
40	Physical Therapy Consultant	6	269	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	256	$ 8,701		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Stipend for Two Sisters Acting as Administrator and	$
Assistant Administrator at $500 Per Month Per Sister	12,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 12,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
R. E. Harrington	Unemploy Comp Consult	$ 393
ADP	Payroll Processing	11,908
Varey & Vaccariello CPAs PC	Accounting and Auditing	34,644
Jackson Lewis Schnitzler	Legal (Care Related)	21
Katten, Muchin & Zavis	Legal (Care Related)	1,457
Cahill, Christian & Kunkle, Ltd.	Legal (Non-Care Related)	3,370
NOTE: Non-Care Related Legal Adjusted Out of Schedule V, Line 19		
(See Page 5, Line 22)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,793

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,042
Unemployment Compensation Insurance	20,960
FICA Taxes	174,683
Employee Health Insurance	201,477
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	56,380
Employee Physicals	5,699
TOTAL (agree to Schedule V, line 22, col.8)	$ 476,241

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,681
Health Care Worker Background Check	660
(Indicate # of checks performed 55)	
Public Relations	28,823
Subscriptions	840
Licenses and Fees	959
Dues - Life Services Network of IL	2,436
Dues - Buying Service	2,262
Dues - Misc	1,437
Less: Public Relations Expense	(28,823)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,275

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repair Soil Pipe	06/98	$ 1,838	3 Yrs	$ 357	$ 613	$ 613	$ 255	$	$	$	$	$
2	Repair A/C Shaft	04/99	2,382	3 Yrs		596	794	794	198				
3	Repair Boiler #2	05/2000	2,315	3 Yrs			514	772	772	257			
4	Plumbing Repair	06/2000	2,290	3 Yrs			446	763	763	318			
5	Painting	08/2000	5,929	3 Yrs			824	1,976	1,976	1,153			
6	Plumbing Repair	09/2000	1,713	3 Yrs			190	571	571	381			
7	Painting	10/2000	11,470	3 Yrs			956	3,823	3,823	2,868			
8	Painting	01/2001	3,594	3 Yrs				1,198	1,198	1,198			
9	Painting	02/2001	13,180	3 Yrs				4,027	4,393	4,393	367		
10	Repair Kitchen HVAC	06/2001	1,650	3 Yrs				321	550	550	229		
11	Painting	10/2001	3,764	3 Yrs				314	1,255	1,255	940		
12	Repairs to HVAC Equip	11/2001	1,818	3 Yrs				101	606	606	505		
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 51,943		$ 357	$ 1,209	$ 4,337	$ 14,915	$ 16,105	$ 12,979	$ 2,041	$	$

Facility Name & ID Number Little Sisters of the Poor # 0025346 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,890** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,508**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **-0-** Has any meal income been offset against related costs? **No** Indicate the amount. $ **-0-**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **25% for Activities Only**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Varey & Vaccariello CPAs PC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Care Related Legal is less than $2500, so no copies attached**
Attach invoices and a summary of services for all architect and appraisal fees.